The evidence, the art, the outcomes

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The Forum for Behavioral Science in Family Medicine was established in 1980 to create opportunities for behavioral scientists to share their work, collaborate with others, and find support. Over four decades, the Forum grew from a local gathering of colleagues to a meeting with presenters and participants from around the globe. Presentations furthered the scientific basis of what we do while supporting the dissemination of creative and meaningful methods for educating physicians, caring for patients, and maintaining wellbeing. 2019 marked the 40th anniversary of the Forum with the theme The Evidence, the Art, the Outcomes. This special issue of The International Journal of Psychiatry in Medicine presents nine articles drawn from that conference.

Strong threads of behavioral science have run through the tapestry of family medicine since its establishment as a specialty in 1969.[1] Like the strong vertical warp threads of a tapestry, scientific evidence creates a necessary framework. Behavioral scientists joined the faculty of residency programs and medical schools. They conducted research in communication skills, educational strategies, behavior change counseling, family systems, disparities, the treatment of psychiatric disorders, and wellbeing. This scholarship contributed to the strong foundational warp in family medicine's tapestry alongside other medical topics. Weft yarns hold the tapestry together, transforming it into a unified fabric, both functional and beautiful. As family medicine matured, behavioral scientists brought depth and sensitivity through medical humanities, narrative medicine, improvisation, creative teaching methods, and professional support. These weft yarns serve to keep clinicians and educators connected to the humanity of our patients, engaged and motivated through difficult times.

Times have indeed been difficult. When the triple aim of health care (improved population health, improved patient experience, and reduced costs) was introduced in 2008, many systems were inspired. Investigation into implementation suggested that the practice environment for providers was a substantial barrier. A fourth aim, provider wellbeing, was proposed.[2] The financial realities of medicine, diminishing time for patient contact, and the electronic health record often obstruct the creative and meaningful practices that promote connection and resilience. As a result, there is an epidemic of burnout in medical professionals.[3] Clinicians and educators have little time or energy to gather the practice-based and patient-oriented data that supports the most practical and generalizable conclusions.[4] Clinicians and educators need help to overcome these obstacles.

Recognizing the need to train the next generation of physicians to participate in practice-based research, the Accreditation Council of Graduate Medical Education (ACGME) in the United States made scholarly activity a requirement.[5] Developing a program of research can seem intimidating to those without knowledge, skills, or institutional supports. In Act Scholarly! Embrace your inner behavioral scientist, Sandra Burge celebrates the history of scholarship in this field and the role it plays in supporting and transforming family medicine. Acknowledging how intimidating it can be to enter the world of research, she challenges us to broaden our view of scholarship. She provides a field guide for initiating a program of scholarly activity, even in situations where participants have limited training, time, and resources.

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Utilizing mentors and collaborators, focusing and integrating scholarship with other work, building writing skills, and developing comfort with basic statistics are elaborated with tips, tricks, and practical resources. She exhorts us to embrace our responsibility to ensure that the scientific foundations of our discipline continue to grow and strengthen.

The medical education process can feel like drinking from a fire hose. Year after year, early career physicians dig deep to learn as much as they can and find the confidence to hold their patients' lives in their hands. This overwhelming process leaves physicians vulnerable to imposter syndrome and burnout. Colleen Fogarty illustrates the art of supporting medical learners in Using kindness, compassion, and connection to help healers learn. She credits Dr. Beat Steiner of the Society of Teachers of Family Medicine (STFM) with advocating the recognition and application of prosocial emotions (e.g., kindness, compassion, gratitude, awe) in the education of family physicians. Extending his ideas, she advocates for a culture change in how we educate physicians. She argues that based upon temperament and training, behavioral science educators are well-positioned to embody and model such changes. Her thesis that embracing prosocial emotions will benefit both teachers and learners is well-supported by our current understanding of emotional intelligence and subjective well-being.[6]

In Narrative Medicine: Re-engaging ourselves through story, readers will find an example of creative education based on science. Lijoi and Tovar provide a compelling illustration of their narrative medicine curriculum. They provide concrete examples of narrative medicine exercises to address professional milestones (e.g., professional behavior, accountability, help-seeking behaviors, interpersonal and communication skills) embedded within the ACGME core competency of professionalism. They provide data to support the impact of their curriculum to date. This excellent example of applied narrative medicine illustrates several known evidence-based outcomes (e.g., relationship building, empathy, resilience, burnout mitigation, professional confidence, and development of ethical inquiry skills).[7,8]

Educators are also vulnerable to burnout. In Putting meaning back in medicine, Huffman and Fazio describe a faculty development curriculum applied at two different residency programs. Their conceptual background rests on the idea that loss of meaning is a major reason for faculty vulnerability to burnout. The curriculum attempts to produce group cohesion and mutual support for rediscovering one's purpose or sense of meaning as a health professional. The authors provide concrete resources (e.g., videos, articles, books) for others to use in attempting similar groups. This work aligns well with what is known about the prevention and mitigation of physician burnout.[9]

Technology brings new opportunities and challenges to medical education. Jenkins and Oyama address this timely topic in Telemedicine: The art of innovative technology in Family Medicine. Initially developed as a method to improve access for a group of underserved patients with diabetes while providing opportunities to teach important patient care skills, the original presentation addressed curriculum, opportunities, and barriers. The onset of the SARS-2 coronavirus pandemic has brought telemedicine into the limelight, thrusting many of us unceremoniously into the brave new world of video/virtual visits. We have been forced to provide patient care and teach medical learners about this process with few guidelines or models. These authors generously share components of their curriculum and lessons learned in implementation. Their model speaks to the challenges involved in introducing telemedicine and lays a foundation for evaluating effectiveness.

Whether virtual or in-person, evidence-based patient care remains the heart of medicine. Primary care physicians frequently care for common and more complex mental health disorders. Bipolar disorder: Managing the peaks and valleys by Johnson, Fields, and Bluett provides an overview of updates to the treatment of bipolar disorders. The authors provide guidelines for assessing patients for Bipolar I and II. Evidence-based treatments include non-pharmacologic interventions and FDA-approved medications. It is fortunate that primary care physicians can care for these patients. The worldwide shortage of psychiatrists necessitates that many patients with bipolar disorder will seek care from primary care physicians. These evidence-based resources support such work.

Good patient care is more than providing the best interventions. The second arm of the triple aim discussed above is the patient experience. Aubry Koehler and colleagues' research, Patient satisfaction with an integrated care model in family medicine, examines how integrated care impacts the patient experience. They extend the framework for conceptualizing mental health treatment in medical contexts. Physical health and mental/emotional health were correlated with patient satisfaction. Nuances of the outcomes have implications for the growing field of integrated behavioral health.

The trauma informed (TI) care movement is an example of how practice-based research can inform the best quality care. Julie Miller-Cribbs and colleagues contribute to the body of evidence focusing on methods for teaching these skills. They investigated ways to help medical professionals adequately address trauma with adults in An evaluation of a simulation and video-based training program to address adverse childhood experiences (ACEs). Using standardized patients and a TI framework, they found that medical and allied health learners can build skills in treating adults with ACEs. The positive and negative changes in trainees throughout the four-year study shed light on future educational adjustments. Results suggest that physicians can benefit from this training model and highlight the areas that are more challenging and may need further attention.

Coming full circle, in Cultivating change: Engaging residents in research, Vikram Arora and his co-investigators undertake the herculean task of improving the research culture at a family medicine residency. Starting with a needs assessment, the researchers evaluate how curricular changes and an enhanced structure for scholarly work can improve outcomes in the department. The results in terms of resident satisfaction, publications, and presentations can serve as a model for other departments looking to augment their scholarly projects.

A foundation of scholarly activity is woven together with artistic implementation in the tapestry of great patient care. Through partnership, support, sharing of research findings and educational strategies, promoting wellbeing and best practices in patient care we help each other improve the discipline. As our health care and teaching environments change, it is easy to lose sight that our mission is the same as it has ever been; to provide the best possible care, supported by the best evidence, and in the most humane way possible. When clinicians and educators work together and share their lessons, insights, and failures the whole discipline advances. When we treat each other with kindness and compassion, we support the relationships that make this work possible.

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References

1. Baird, MA, Hepworth, J, Myerholtz, L, et al. Fifty years of contributions of behavioral science in family medicine. Fam Med 2017; 49: 296–303.

2. Bodenheimer, T, Sinsky, C. From triple to quadruple aim: care of the patient requires care of the provider. Ann Fam Med 2014; 12: 573–576.

3. Shanafelt, TD, Hasan, O, Dyrbye, LN, et al. Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. Mayo Clinic Proc 2015; 90: 1600–1613.

4. Ammerman, A, Smith, TW, Calancie, L. Practice-based evidence in public health: improving reach, relevance, and results. Ann Rev Public Health 2014; 35: 47–63.

5. Accreditation Council for Graduate Medical Education. Common program requirements , https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRResidency2020.pdf (accessed 29 July 2020).

6. Sanchez-Alvarez, N, Extremera, N, Fernandez-Berrocal, P. The relationship between emotional intelligence and subjective well-being: a meta-analytic investigation. J Posit Psychol 2016; 11: 276–285.

7. Charon, R. Narrative medicine: a model for empathy, reflection, profession, and trust. J Am Med Assoc 2001; 286: 1897–1902.

8. Remein, CD, Childs, E, Pasco, JC, et al. Content and outcomes of narrative medicine programmes: a systematic review of the literature through 2019. BMJ Open 2020; 10: e031568.

9. West, CP, Dyrbye, LN, Shanafelt, TD. Physician burnout: contributors, consequences, and solutions. J Intern Med 2018; 283: 516–529.